REQUEST FOR AN ACCOUNTING OF DISCLOSURE OF PROTECTED HEALTH INFORMATION BY PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

File Number:_____

You have the right to request the Department of Health Services to account for the disclosures of your Medi-Cal information. You are not entitled to an accounting of disclosures to carry out treatment, payment, or health care operations; when you have authorized the disclosure; or when the disclosure is to your family, relatives, or others involved in your care. You are also not entitled to an accounting of disclosures for National Security or intelligence purposes and to law enforcement officials. A photocopy of your identification and documentation of your address must accompany this form. Mail this completed form to:

Department of Health Services
EDS Communications
P.O. Box 526018
Sacramento, CA 95852-6018

INDIVIDUAL WHOSE INFORMATION YOU ARE REQUESTING			
LAST NAME:	FIRST NAME:		MIDDLE INITIAL:
ADDRESS:	CITY/STATE:		ZIP CODE:
BENEFICIARY ID NUMBER:	DATE OF BIRTH:	DATE OF DEATH: (IF APPLICABLE)	
DEATH CERTIFICATE MUST BE ATTACHED			
PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE INFORMATION			
LAST NAME:	FIRST NAME:		MIDDLE INITIAL:
ADDRESS:	CITY/STATE:		ZIP CODE:

DAYTIME TELEPHONE NUMBER: ( )	EVENING TELEPHONE NUMBER: ( )	EMAIL ADDRESS:	BEST HOURS TO REACH YOU:

WHAT LEGAL AUTHORITY DO YOU HAVE TO REQUEST AN ACCOUNTING OF DISCLOSURES OF THE INDIVIDUAL ABOVE?

☐ PARENT ☐ CONSERVATOR

☐ GUARDIAN ☐ EXECUTOR OF WILL

☐ MEDICAL POWER OF ATTORNEY ☐ OTHER

PLEASE ATTACH LEGAL DOCUMENTATION VERIFYING THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE INDIVIDUAL.

IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE:_____ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFICIARY IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER:_____

I REQUEST THAT THE DEPARTMENT OF HEALTH SERVICES ACCOUNT FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION.

FROM: _____(MONTH/YEAR) TO: _____(MONTH/YEAR)

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

BENEFICIARY SIGNATURE:_____DATE:_____

(IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.)

NOTARIZED BY: _____ ON _____ (DATE)

NOTARY PUBLIC NUMBER: _____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC:

☐ ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION _____ (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.